

ADULT SHEET

A

PATIENT'S NAME _____ AGE _____

REASON FOR TODAY'S VISIT _____

MEDICATIONS

List present medications & dosage: 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Do you take Aspirin/Advil/Tylenol on a regular basis? YES NO Vitamins or Non-Prescription Meds? YES NO

Are you allergic to any medications? YES NO (Please List) _____

Other Allergies (please list): _____

Are you currently pregnant? YES NO Are you currently on a contraceptive medication program? YES NO

PAST MEDICAL HISTORY (type & date):

Any & All Hospitalizations: 1. _____ 2. _____ 3. _____
Any & All Operations: 1. _____ 2. _____ 3. _____
Any & All Illnesses: 1. _____ 2. _____ 3. _____
Any & All Injuries: 1. _____ 2. _____ 3. _____

SOCIAL HISTORY:

Smoke: YES NO _____ packs per day Quit date _____ Caffeine: YES NO _____ cups per day
Alcohol: YES NO _____ type/amount Diet: _____ type

FAMILY HISTORY (check any that apply):

Asthma Diabetes Tuberculosis High Blood Pressure Stroke Autoimmune Disease Heart Disease Headaches
 Allergies Cancer Thyroid Disease Bleeding Problems Problems with Anesthesia Hearing Loss

REVIEW OF SYMPTOMS (check any that apply):

EARS: Hearing Loss Tinnitus (noise in ears) Dizzy (vertigo) Pain Discharge Hearing Aid
 Exposure to Loud Noise Surgery

NOSE: Difficulty Breathing Stiffness Bleeding Change in Smell Post Nasal Drip
 Injuries Nasal Sprays Snoring Surgery

THROAT: Soreness Pain or Difficulty Swallowing Voice Change / Hoarseness Tonsillitis Bad Breath Bad Taste
 Throat Clearing Lump Recent Dental Work Surgery

NECK: Lumps Thyroid Nodules Pain Injuries Swollen Glands Surgery

GENERAL:

Headaches Stroke Paralysis Loss of Vision Glaucoma Eye Disease
 Cough Asthma Chronic Lung Disease Tuberculosis Shortness of Breath Emphysema
 Heart Attack Angina/Chest Pain Heart Failure High Blood Pressure Arrhythmia (abnormal heartbeats) Rheumatic Fever
 Kidney Disease Prostate Problems Kidney Stones Difficulty Urinating Vaginitis Are you pregnant?
 Weight Loss or Gain Heartburn Reflux Ulcers Liver Disease (Hepatitis or Jaundice)
 Diarrhea Constipation Colitis Lyme Disease Diabetes Psoriasis Eczema Rashes Cancer Anxiety
 Bleeding Problems Anemia Easy Bruising

Is there anything else about your medical history that might be helpful for the doctor to know? YES NO

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

PATIENT SIGNATURE: _____ DATE: _____